Commodity Supplemental Food Program (CSFP) Application

Name (Responsible Adult)____

Address____
(Number/Street) (City) (Zip) (County)

Social Security No.____________________ Phone_________________ Household Size____

Qualifying Household Members:	Age:	Date of Birth:	Category: (infant, child, pregnant, postpartum, breastfeeding woman, or elderly)	What is your ethnic category: (select only one)		What is your race? (select one or more)	
					Hispanic or Latino		American Indian or Alaska Native
							Asian
					Not Hispanic or Latino		Black or African American
							Native Hawaiian or Other Pacific Islander
							White

RACIAL/ETHNIC HERITAGE: This information is for reporting purposes only. You do not have to give us this information however, providing this information will help us to follow the Federal Civil Rights Law. If you do not provide this information, it will not affect your case.

CERTIFICATION STATEMENT. This application is being completed in connection with the receipt of Federal assistance. Program officials may verify information on this form. I am aware that improper use or receipt of CSFP benefits may lead to a claim against the participant to recover the value of the benefits, and may lead to disqualification from CSFP; the participant further understands that changes in household income or composition must be reported within 10 days after the change becomes known to the household. I am also aware that I may not receive both CSFP and WIC benefits simultaneously, and may not receive CSFP benefits at more than one CSFP site at the same time. Furthermore, I am aware that the information provided may be shared with other organizations to detect and prevent dual participation. I have been advised of my rights and obligations under the program. I certify that the information I have provided for my eligibility determination is correct to the best of my knowledge.

I authorize the release of information provided on this application form to other organizations administering assistance programs for use in determining my eligibility for participation in other public assistance programs and for program outreach purposes. (Please indicate decision by placing a checkmark in the appropriate box.) YES ___ NO ___

____

Signature of Applicant **Date**

____

Name/Signature of Proxy (optional) **Date**

"In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability." To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call (800)795-3272 (voice) or (202)720-6382 (TTY). USDA is an equal opportunity provider and employer."

APPLICANT'S RIGHTS: 1) Standards for participation in the Program are the same for everyone regardless of race, color, sex, national origin, age or disability. **2)** You may appeal any decision made by the local agency regarding your denial or termination from the Program. You have a right to a fair hearing. **3)** If your application is approved, the local agency will make nutrition education available to you and you are encouraged to participate. **4)** The local agency will also provide information on nutrition, health or assistance programs and make referrals as appropriate.

APPLICANT'S RESPONSIBILITIES: Failure to comply with the rules below may result in disqualification from participation in the Commodity Supplemental Food Program. **1)** Do not make false statements orally or in writing in order to obtain benefits to which you or your household would not otherwise be eligible. **2)** Do not conceal information in order to obtain benefits for which you are not eligible. **3)** Do not alter Program documents for the purpose of receiving increased benefits for which you are not eligible or for the purpose of transferring benefits to an unauthorized individual. **4)** Do not use supplemental foods in an unauthorized manner, such as trading or selling the foods. **5)** Do not commit dual participation.

For Office Use Only

Date of initial visit household applied for participation: ____________ Identification Verified:___

Criteria used to determine the person's eligibility or ineligibility:

Categorically eligible [ ] Yes [ ] No

REFERRAL: Income eligible under existing Federal, State, or local food, health, or welfare programs
[ ] Yes [ ] No [ ] NA List Program ______________________________

Resides in local agency service area [ ] Yes [ ] No [ ] NA

HOUSEHOLD INCOME	Gross Amount	How often received
- Social Security	____________	____________
- Pension, Retirement	____________	____________
- Wages, Salary	____________	____________
-TANF, General Assistance	____________	____________
- SSI	____________	____________
- Unemployment, Worker's Comp.	____________	____________
- Other (Specify):____________	____________	____________

TOTAL HOUSEHOLD GROSS MONTHLY INCOME: $ ____________________

ELIGIBILITY DETERMINATION

[ ] Approved: Certification Period: __________ to __________

____ _____________________

Signature/Title of Certifier Date of Certification

[ ] Re-certification Period (Elderly Only): __________ to __________

Client wishes to remain on CSFP for a consecutive six months? ☐ Yes ☐ No

Client contacted by: Phone: __________ In Person ____________________

Has client's address changed? ☐ Yes ☐ No If yes, new address:____________________

Re-certification Approved by:______________________________Date:______________

Signature/Title of Certifier

[ ] Denied due to: ____

____ _____________________

Signature/Title of Certifier Date of Denial

Written Information Provided (circle): Nutrition, Medicaid, TANF, other health insurance programs for low-income households, Food Stamp Program, SSI, Medicare, Child Support, and WIC.

Referrals made, if applicable: ____

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